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No. 01-845

In The

Supreme Court of the United States

WILLIAM JOHN NICHOLAS, M.D.,

Petitioner,

v.

NORTH COLORADO MEDICAL CENTER, INC., a Colorado corporation and its Governing Board of Directors; RICHARD H. STENNER, its President; KARL B. GILLS, its Executive Vice-President; ALYCE KANTNER, its former Director of Medical Services; and PAT (WILSON) KERN, its Director of Cardiovascular Services,

Respondents.

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On Petition For Writ Of Certiorari
To The Colorado Supreme Court

BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

JEROME M. REINAN
Counsel of Record
2150 W. 29th Ave., 5th Floor
Denver, CO 80211
Telephone: (303) 894-0383
Fax number: (303) 894-0384
Counsel for Respondents

COCKLE LAW BRIEF PRINTING CO., (800) 225-6964
OR CALL COLLECT (402) 342-2831

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Respondents North Colorado Medical Center, Inc., a Colorado corporation and its Governing Board of Directors; Richard H. Stenner, its President; Karl B. Gills, its Executive Vice-President; Alyce Kantner, its former Director of Medical Services; and Pat (Wilson) Kern, its Director of Cardiovascular Services (herein "Respondents"), respectfully pray that the Court deny the Petition for Writ of Certiorari to review the final judgment and decision of the Supreme Court of the State of Colorado entered in the above proceedings on August 6, 2001.

OPINIONS BELOW

The final opinion of the Colorado Supreme Court decided June 25, 2001, as modified on denial of rehearing on August 6, 2001, was reported at 27 P.3d 828, and is reprinted in the Appendix to the Petition for Certiorari at App. 1-37. The August 6, 2001 Order of the Court modifying the June 25, 2001 opinion, and denying Petitioner's Petition for Rehearing is reprinted in the Petition for Certiorari, App. 79-80. The Colorado Supreme Court reversed the opinion of the Colorado Court of Appeals decided on December 9, 1999, as modified on Denial of Rehearing and reported at 12 P.3d 280, reprinted in the appendix to the Petition for Certiorari, App. 38-58. The Order Granting Partial Summary Judgment in favor of Respondents on the claim for relief pursuant to 42 U.S.C. § 1983 is reprinted in the appendix hereto, App. 1-2. The trial court's order denying reconsideration of its Order

pursuant to 42 U.S.C. § 1983 is reprinted in the appendix hereto, App. 3-5. The Findings of Facts, Conclusions of Law and Order of Immunity issued by the trial court is reprinted in the appendix hereto, App. 6-15.

CONSTITUTIONAL PROVISIONS AND STATUTES INVOLVED

In addition to those constitutional provisions and statutes cited in the Petition, the following pertinent language contained in the *Health Care Quality Improvement Act of 1986*, found at 42 U.S.C. § 11111 through 11115 (herein "HCQIA") is:

> **§ 11112(a) In general**
>
> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken –
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
>
> A professional review action shall be presumed to have met the preceding standards necessary

for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

STATEMENT OF THE CASE

Respondent North Colorado Medical Center, Inc. (herein "NCMC") is a 326 bed general acute hospital situated in Greeley, Colorado. At all times relevant it has been incorporated as a private, not for profit corporation pursuant to 26 U.S.C. § 501(c)(3). The individually-named Respondents, Richard H. Stenner, Karl B. Gills, Alyce B. Kantner and Pat (Wilson) Kern were at times relevant employees and executives of NCMC who participated in Nicholas's professional review process. For the sake of brevity, Respondents will be collectively referred to as "NCMC" or "the hospital" unless otherwise noted.

Petitioner William John Nicholas, M.D. (herein "Nicholas") is an invasive and interventional cardiologist, specially trained to place catheters into the human heart to prevent or terminate heart attacks and to conduct invasive studies of the vessels of the heart.

In 1989, Nicholas, who had just completed his invasive cardiology training, accepted employment with the Greeley Medical Clinic (herein "GMC"), an association of physicians in Greeley, Colorado. At the time, there were three other invasive cardiologists employed by GMC. Since GMC did not have a cardiac catheterization laboratory on site, Nicholas sought and obtained provisional

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privileges[1] to practice at NCMC, which owned and operated a cardiac catheterization laboratory.

Shortly after Nicholas's arrival, the hospital's Medical Quality Assurance Committee (Q.A. Committee) began to receive reports of adverse incidents associated with Nicholas's cases. During the pendency of the investigation of Nicholas's practice, his privileges in the cardiac catheterization lab were summarily suspended by Nicholas's cardiology proctor. (Record, Vol. 2, p. 326; Vol. 11, p. 2973) At the same time, Nicholas's employment with GMC was terminated by unanimous consent of its cardiology department, based upon serious concerns over Nicholas's practice. (Record, Vol. 2, p. 315; p. 323)

Contrary to the allegations made by Nicholas in his Brief, the record demonstrates that it was Nicholas's termination from GMC, his suspension from the cardiac catheterization laboratory and the gravity of the cases already under review by the Quality Assurance Committee that led the committee to seek an independent, outside review of Nicholas's practice. (App. 16-18; Record, Vol. 2, pp. 315, 323, 326; Vol. 11, p. 2973) A well-regarded expert from California was retained for this review.

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[1] As per NCMC's medical staff bylaws, all new staff appointees at NCMC were required to undergo a proctorship with an active member of the medical staff and remain on provisional status for one year. At the end of the year, the provisional staff member could request advancement to the active or courtesy staff as per the bylaws. In no case could a provisional staff member remain on the provisional staff for more than two years.

Following a site visit, staff interviews, an interview with Nicholas and a review of relevant medical records and catheterization films, the outside expert concluded that Nicholas demonstrated severe deficiencies in his invasive cardiology practice. (Record, Vol. 26, pp. 1653-56)

On July 2, 1991, NCMC's Credentials Subcommittee – which is charged with making recommendations as to physician privileges – reviewed Nicholas's request for advancement to active status on the medical staff. In so doing, it considered and received the concerns of the QA Committee, the report of the outside reviewer, and a response from Nicholas.

Following deliberation and review, the Credentials Subcommittee determined that Nicholas's continued invasive cardiology practice posed a risk to the health and welfare of the patients of NCMC and directed Respondent Stenner, President of NCMC, to summarily suspend Nicholas's invasive cardiology privileges pending further investigation and review as per the hospital's bylaws. (Record, Vol. 11, p. 2974; Vol. 32, T. 1, Appendix A, July 2, 1991 Minutes)

The Credentials Subcommittee thereafter retained three additional independent cardiologists to review Nicholas's practice. The Credentials Subcommittee also interviewed numerous witnesses from the medical and nursing staff, including Nicholas. The three outside reviewers returned criticisms of Nicholas's practice that equaled – if not exceeded – those made by the first expert. Among other things, one reviewer found Nicholas's approach to a particular case "dangerous and irresponsible" while another reviewer found Nicholas's

practice to be "below accepted standards of care," with his documentation of the case "extremely poor, and in fact, inaccurate. . . . " The third reviewer concluded that Nicholas prescribed a contraindicated drug for one of his patients, causing her death. (Record, Vol. 26, pp. 1555-73) The investigation by the Credentials Subcommittee revealed additional concerns regarding Nicholas's practice, including personality conflicts with staff and allegations of dishonesty.

The Credentials Subcommittee recommended that NCMC suspend Nicholas's invasive cardiology privileges pending further review. This recommendation triggered NCMC's Fair Hearing Plan, which entitled Nicholas to a hearing before an impartial panel of three physicians not in competition with Nicholas. The Fair Hearing Panel met in March, 1992, and received testimony, argument and exhibits from Nicholas, through his attorney, and also from the Credentials Subcommittee, through its attorney.

The Fair Hearing Panel concluded, *inter alia*, that Nicholas continued to exhibit "a definite inability to form a rational treatment plan based on a logical progression of thought." It recommended that Nicholas receive invasive cardiology privileges, but that he be proctored for a period of time and that his cases continue to be monitored by another physician, at Nicholas's expense. (Record, Vol. 11, p. 2974; Vol. 36, pp. 145-6)

Both Nicholas and the Credentials Subcommittee appealed the Fair Hearing Panel's recommendations to the House Committee of the Board of Directors. In May, 1992, the House Committee met to determine the appeals.

The process included receiving the report of the Credentials Subcommittee, the report of the Fair Hearing Panel, the transcript of the Fair Hearing, all exhibits introduced at the Fair Hearing, the written appeals of Nicholas and the Credentials Subcommittee, and argument of counsel for both parties.

Following extensive deliberation, the House Committee found that the Fair Hearing Panel and the Credentials Subcommittee had reached essentially the same conclusion, namely, that Nicholas exhibited deficiencies in both medical judgment and documentation. However, the House Committee determined that a more appropriate remedy was continued suspension of Nicholas's invasive cardiology privileges with the ability to apply for reinstatement of his privileges after one year. (Record, Vol. 11, p. 2975; Vol. 36, p. 153)

The House Committee felt that this remedy was sufficient for Nicholas to maintain his non-invasive privileges at NCMC while seeking additional training in invasive cardiology. The Board of Directors of NCMC[2] approved the House Committee's recommendation.

Following the board action, Nicholas filed an anti-competitive conduct complaint with the Committee on

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[2] Nicholas alleges, at p. 8, that "[m]embers of the investigative subcommittee were also members of the Board of Directors. This is an inaccurate implication. Only one member of the Credentials Subcommittee – Ken Lind – actually participated in the decision of the Board of Directors. The other joint member, Dr. Paul Hiratzka, recused himself from the Board's deliberations.

Anticompetitive Conduct (herein "CAC")[3] and a separate civil damages suit in the Weld County District Court.

The instant civil damages suit includes numerous claims for relief, including a claim under 42 U.S.C. § 1983. On December 4, 1997, the trial court granted summary judgment in favor of the Respondents on Nicholas's § 1983 claim. (App. 1-3) Nicholas petitioned the trial court for reconsideration of its decision on the § 1983 claims, arguing that the court had improperly found NCMC to be a private hospital, in derogation of *Milo v. Cushing Mun. Hosp.*, 861 F.2d 1194 (10th Cir. 1988). In its January, 1998 order denying the motion for reconsideration, the trial court further explained its ruling on the § 1983 claims. (App. 4-7)

The court noted that there was "no dispute" as to the fact that NCMC was a private hospital. (App. 5) The decision was based upon voluminous documents filed with the Court, including documents attached to Nicholas's Petition at App. 81-144, affidavits and deposition transcripts untraversed by Nicholas.

From January 26 through February 6, 1998, the trial court held a hearing to determine whether Defendants were entitled to immunity pursuant to C.R.S. § 12-36.5-101, *et seq.* and 42 U.S.C. § 11111, *et seq.* Both sides presented evidence, called witnesses and argued the law in support of their positions. During the course of

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[3] As discussed in Petitioner's brief, the CAC is the Committee on Anticompetitive Conduct, which was created by the Colorado Professional Review Act (herein "CPRA"), C.R.S. § 12-36.5-106.

the hearing, Nicholas stipulated that the conduct of the hospital's Medicine QA Committee, Credentials Subcommittee and Fair Hearing committees was reasonable, appropriate, and undertaken in good faith. (App. 10-11)

The remaining issues to be determined by the trial court were whether the conduct of the NCMC House Committee and Board of Directors fell within the immunity standards set forth under the CPRA and HCQIA. On June 5, 1998, the trial court made detailed findings and fact and conclusions of law and entered summary judgment in favor of Defendants and against Plaintiff under the immunity provisions of CPRA and HCQIA. (App. 8-28)

Nicholas appealed the trial court's dismissal of the § 1983 claims as well as the court's June 5, 1998 order of summary judgment. In its modified decision of April 13, 2000, the Colorado Court of Appeals reversed the trial court on all issues, and remanded for further proceedings.

In its decision rendered August 6, 2001, the Colorado Supreme Court reversed the Colorado Court of Appeals. It held, *inter alia*, that professional peer review conducted by private medical facilities does not constitute state action for the purposes of 42 U.S.C. § 1983. It further held that, as a matter of law, the conduct of the Respondents and their various committees satisfied the immunity provisions of the CPRA and HCQIA thereby conferring statutory immunity from suit and damages. Nicholas now seeks this Court's writ of certiorari.

ARGUMENT

S. Ct. Rule 10 illustrates some of the considerations governing review on certiorari. It states, *inter alia*, that, "a petition for a writ of certiorari will be granted only for compelling reasons." It further states that "a petition for writ of certiorari is rarely granted when the asserted error consists of erroneous factual findings or the misapplication of a properly stated rule of law."

The reasons for review advanced by Nicholas in his petition are neither compelling nor indicative of a misapplication of existing law by the Colorado Supreme Court. Rather, Nicholas argues that the Colorado Supreme Court made erroneous factual findings and/or misapplied the law in his case.

Respondents contend that apart from lack of a compelling issue, this Court should deny the petition because the Colorado Supreme Court correctly followed established state and federal law, and its decision does not conflict with the decisions of this Court or the decisions of federal circuit courts of appeal deciding similar issues.

I.

THE COLORADO SUPREME COURT'S RULING ON NICHOLAS'S § 1983 CLAIMS IS NEITHER AN IMPORTANT FEDERAL QUESTION NOR IN CONFLICT WITH RELEVANT DECISIONS OF THIS COURT

The Colorado Supreme Court's determination that NCMC is a private hospital, as a matter of law, is not a "compelling" issue or a finding inconsonant with decisions of this Court. The decision was correct in light of

the record, and the best Nicholas can argue is that the decision *misapplies* the law, as opposed to *conflicts* with federal case law.

Nicholas argues that the Court should not have analyzed NCMC's "private/public" status under the "fair attribution" test of *Lugar v. Edmondson Oil Company, Inc.*, 457 U.S. 922, 102 S. Ct. 2744, 73 L. Ed. 2d 482 (1982) because NCMC was a public or quasi-public entity. He contends that the Court should have applied the "public function" test under *Burton v. Wilmington Parking Authority*, 365 U.S. 715, 81 S. Ct. 856, 6 L. Ed. 2d 45 (1961) and *Milo v. Cushing Mun. Hospital*, 861 F.2d 1194 (10th Cir. 1988). Nicholas's legal analysis is incorrect.

The Colorado Supreme Court applied the proper test under *Lugar, supra*, and as discussed below, the outcome would have been the same even if the "public function" test been employed.

The "public function" test is improper in the case at bar because it presupposes a relationship between the state and the private entity so intertwined that the actions of the private entity are deemed to be those of the state. For example, the private hospital in *Milo* – the facts of which form the basis of Nicholas's argument – was governed by a Board of Trustees established under 60 OKLA. ST. ANN. § 176. Under that statute, the board was comprised of state officials clothed with the same authority and responsibility as elected public officials. *See, Tarabishi v. McAlester Regional Hospital*, 827 F.2d 648 (10th Cir. 1987). In fact, the trustees were public officials who were required to take an oath of office. *Id.*

As a result of this enabling statute, the court held, as a matter of law, that such facilities *in Oklahoma* are public hospitals because the management of state and hospital are significantly intertwined. *Milo* at 1196. By comparison, the "enabling statute" in the instant matter, C.R.S. § 25-3-302(1), requires the opposite result. That statute provides that hospital trustees shall not be "elective or appointed state, county or city officials," and thus not clothed with state authority.

The hospital in *Milo, supra,* is also structurally distinguishable from NCMC. In *Milo,* the city continued to maintain a significant amount of control over the hospital's operations, whereas Weld County has *no authority* over NCMC. In *Milo,* the city was entitled to take the profits of the hospital, and the five-person board of trustees was comprised of a majority of city commissioners. The hospital was supported by city mill levies, and the hospital was ultimately accountable to the city.

None of those factors are present at NCMC. At all relevant times, NCMC's board was comprised of a majority of non-trustees.[4] (Record, Vol. 7, p. 1639) The minority trustee members were independent from the county commissioners, and by law, were not state officials. Weld County did not take profits from NCMC, and NCMC was not required to report to Weld County. (Record, Vol. 7, p.

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[4] Although Nicholas argues that the trustees constituted a "majority" of the NCMC Board in 1991, the record reflects that as of 1992 – when the final board action was entered – a minority of the members of the NCMC Board were Trustee members. (Petitioner's App. 111-112).

1638) Weld County had no authority over NCMC's management, and took no part in its credentialing decisions. (Record, Vol. 6, pp. 1193-1257; pp. 1511-13; (Petitioner's App. 9-10). Although the hospital had previously received county tax dollars, by the time of the final board action in 1992, NCMC no longer collected tax levies from Weld County[5]. (Vol. 6, p.1485)

The Court therefore properly applied the tests set forth in *Lugar* and *Blum v. Yaretsky*, 457 U.S. 991 (1982). However, even if the Court had followed the test annunciated in *Milo, supra,* and *Burton, supra,* the same result would have been reached.

Under the "public function" test, the Court should consider three factors in determining whether a private hospital is a state actor for purposes of § 1983: (1) whether the County receives a "direct financial benefit" from the private lessee; (2) whether the County "benefitted" from the actual complained of violation(s); and (3) whether the County retained "control [of] and responsibility" for the hospital; *Moore v. Wyoming Medical Center,* 825 F.Supp. 1531 (D. Wyo. 1993), *relying upon Milo, supra,* and *Jatoi v. Hurst-Euless-Bedford Hosp. Auth.*, 807 F.2d 1214 (5th Cir. 1991).

Nicholas cannot proffer any evidence that Weld County somehow "benefitted" from the restriction of

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[5] The document upon which Nicholas relies to demonstrate that NCMC received county tax support shows mill levies spent in 1989 and 1990, long before the final board action in the instant matter, and before NCMC restructured the composition of its Board of Directors. (Petitioner's App. 109).

Nicholas's privileges. He is similarly unable to demonstrate that the County exercised control of or responsibility over the hospital and its credentialing function. As a result, the Court's supposed misapplication of the law had no effect on the outcome of the case, and is therefore a reason insufficient to seek this Court's review.

II.

"STATE ACTION" UNDER THE CPRA IS NOT STATE ACTION SUFFICIENT TO SUPPORT A § 1983 CLAIM

Nicholas next argues that the Colorado Supreme Court *misapplied* the law when it determined that "active state supervision" for the purpose of antitrust immunity is different than "state action" under § 1983. Nicholas is incorrect. In addition, the meaning of the CPRA involves an interpretation of state law, which makes it a less compelling issue for this Court's review. *See, e.g., Lehman Bros. v. Schein*, 416 U.S. 386 (1974).

The doctrine of state action immunity originated with *Parker v. Brown*, 317 U.S. 341 (1943). It provides that a private entity's activity is insulated from antitrust liability if its anticompetitive conduct furthers an important state interest. State action immunity requires that the activity be clearly articulated and affirmatively expressed as state policy, and the state must actively supervise the activities of the private entity. *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 633 (1992).

"State action" under § 1983 is an entirely different concept. § 1983 requires that the activity performed by the private entity has been "traditionally the exclusive prerogative of the state," *Rendell-Baker v. Kohn*, 457 U.S.

830 (1982), and must also be "fairly attributable to the state." *Lugar, supra.*

Contrary to Nicholas's assertions, the CPRA does not transform professional review at private hospitals into § 1983 "state action." As correctly expressed by the Colorado Supreme Court, "the Sherman Act was directed toward 'individual and not state action,' and that state regulatory schemes cannot violate it." (Petitioner's App. 13, *citing California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 104 (1980)). Moreover, the enactment of the CPRA does not change the fact that professional review by private hospitals "has not been viewed as the prerogative of the state." (Petitioner's App. 11, *citing Berg v. Shapiro*, 948 P.2d 59, 61 (Colo. App. 1997)). *See also, Wong v. Stripling*, 881 F.2d 200, 202 (5th Cir. 1989).

The Court was also correct in its holding that "state action" for the purposes of § 1983 is different than state action for the purposes of antitrust immunity. "Similar sounding phrases often have different meanings when applied in different legal contexts. This is such a case. . . . [T]he elements required for a cause of action under section 1983 differ from the elements required for state action under the antitrust laws." (Petitioner's App. 14, *citing Ezpeleta v. Sisters of Mercy Health Corp.*, 800 F.2d 119, 122 (7th Cir. 1986)).

The CPRA was created in response to this Court's decision in *Patrick v. Burget*, 486 U.S. 94 (1998). *See, Frederick W. Yu,* THE COMMITTEE ON ANTICOMPETITIVE CONDUCT: NEW AGENCY ON THE BLOCK, 21 Colo. Law. 31 (January, 1992). The CPRA creates a system of active supervision of the credentialing activities of all hospitals

via the Committee on Anticompetitive Conduct (herein "CAC"), an independent committee of the Colorado Board of Medical Examiners. C.R.S. § 12-36.5-106(1). The CAC's *sole purpose* is to oversee any professional review proceeding which was allegedly the result of "anticompetitive conduct." C.R.S. § 12-36.5-106(9)(f).

Under the CPRA, a physician affected by a credentialing decision allegedly resulting from anticompetitive conduct has as his *sole and exclusive remedy* a proceeding before the CAC. The CAC does not have the power to award damages, but rather has the power to disapprove, set aside or modify any professional review action that resulted from anticompetitive conduct. C.R.S. § 12-36.5-106(9)(k).[6] Physicians aggrieved by the credentialing process may therefore pursue claims for civil damages in a parallel state court action, but may not bring an antitrust claim in that action. § 106(7).

The CPRA does not impose any standards on professional reviewers. It merely grants immunity to reviewers who act in good faith and provide the physician with proper notice and hearing procedures. *See*, §§ 104, 105. It

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[6] The CPRA also provides "safe harbor" immunity which essentially parrots the immunity provisions of the Federal Health Care Quality Improvement Act (herein "HCQIA"), 42 U.S.C. § 11111, *et seq*. Under the CPRA, hospitals engaging in peer review, as well as the members and participants in the peer review process are granted immunity from suit, so long as they follow the prescribed notice, hearing and factfinding requirements. C.R.S. § 12-36.5-104. Those individuals and entities are also afforded "good faith" immunity under the statute. § 105.

is designed to shield and immunize peer review organizations meeting its requirements. It is not, as Nicholas suggests, a sword for use by aggrieved physicians to *require* notice, hearing and factfinding procedures of private hospitals.

The CPRA does not require, as a condition of immunity,[7] that a hospital fully and completely insulate its adjudicatory process from its investigative processes. As the Colorado Supreme Court correctly noted, "there is no logical or legal inconsistency in a certain mixing of investigative and adjudicative roles in administrative proceedings." (Petitioner's App. 34, *citing Withrow v. Larkin*, 421 U.S. 35 (1975)).

There is also no requirement that the NCMC Board blindly adopt the conclusions and recommendations of the Fair Hearing Panel. Several circuit courts facing similar facts have ruled in favor of immunity for hospital boards that have modified, ignored or otherwise failed to adopt the credentialing recommendations made by a physician hearing panel. *See, e.g., Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1332-33 (11th Cir. 1994); *Gabaldoni v. Washington County Hospital Ass'n*, 250 F.3d 255 (4th Cir. 2001); and *Sugarbaker v. SSM Health Care*, 190 F.3d 905 (8th Cir. 1999).

Finally, "decisions that take place during the peer review process in a private hospital 'ultimately turn on medical judgments made by private parties according to

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[7] In *Sugarbaker, Bryan,* and *Gabaldoni, supra,* circuit courts upheld immunity in cases where there was clear commingling of the investigative and adjudicative processes.

professional standards that are not established by the State.' " (Petitioner's App. 11, *citing Blum v. Yaretsky, supra,* 457 U.S. at 1008). The decision to suspend Nicholas's invasive cardiology privileges was based upon medical criteria developed by the physicians on NCMC's professional review committees, and was "not compelled or even influenced by any state regulation." (Petitioner's App. 12, *citing Rendell-Baker, supra* at 841). As a result, the CPRA does not transform professional review by private hospitals into state action for the purposes of § 1983.

In short, Nicholas asks this Court to review the Colorado Supreme Court's interpretation of state law governing peer review. This is in and of itself sufficient reason for this Court to decline certiorari on this issue.

To the extent that the Court's interpretation of the CPRA touches on federal law, this Court should decline review because the Colorado Supreme Court applied legal standards consistent with the decisions of this Court.

III.

THE IMMUNITY PROCEDURE REQUIRED BY THE HCQIA WAS CORRECTLY INTERPRETED BY THE COLORADO SUPREME COURT

Nicholas's final argument is that the Colorado Supreme Court misapplied the legal standard for statutory immunity under the HCQIA. In support of this position, Nicholas argues that the Court erred in deciding immunity issues *de novo,* and as a matter of law, in the face of disputed factual matters. The procedure proposed by Nicholas – that any "disputed fact" be decided by a

jury – is untenable and contrary to the letter and spirit of HCQIA.

42 U.S.C. § 11112(a) gives NCMC a *presumption* of immunity. That presumption can be rebutted only if Nicholas demonstrates, by a preponderance of the evidence, that NCMC did not undertake the action in the furtherance of quality health care; that it didn't act to reasonably obtain the facts; that it didn't provide adequate notice and hearing; or that it didn't act in the reasonable belief that the action was warranted by the facts.

Courts are empowered to determine issues of immunity after the record has been sufficiently developed. *See, e.g., Harlow v. Fitzgerald*, 457 U.S. 800 (1982). The purpose underlying the prompt judicial determination of immunity is to prevent defendants from being subjected to the prohibitive costs of defending meritless claims. *Id.*

HCQIA clearly authorizes (and even encourages) courts to determine immunity issues prior to trial. *See, e.g., Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1332-33 (11th Cir. 1994); *Gabaldoni v. Washington County Hospital Ass'n*, 250 F.3d 255 (4th Cir. 2001); *see also, Sugarbaker v. SSM Health Care*, 190 F.3d 905 (8th Cir. 1999); *Brader v. Allegheny General Hospital*, 167 F.3d 832 (3rd Cir. 1999).

In ruling on HCQIA immunity, the court must utilize "an unconventional standard in determining whether [the peer reviewer] was entitled to summary judgment – whether a reasonable jury, viewing all facts in a light most favorable to [the physician], could conclude that he had shown, by a preponderance of the evidence, that [the

peer reviewer's] actions fell outside the scope of § 11112(a)." *Gabaldoni, supra; see also, Sugarbaker, supra; Brader, supra.* "Only disputes over facts that might affect the outcome of the suit under the governing law will properly preclude the entry of summary judgment. Factual disputes that are irrelevant or unnecessary will not be counted." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

The Colorado Supreme Court correctly followed these precepts in determining that Respondents are entitled to immunity from damages as a matter of law. It determined, notwithstanding Nicholas's arguments that the CAC found the existence of anticompetitive motives,[8] that NCMC reasonably believed that the restriction of Nicholas's invasive privileges "would restrict incompetent behavior or would protect patients." (Petitioner's App. 20).

The Court properly determined that NCMC had restricted the privileges only after extensive investigation, hearing and factfinding had taken place, including the review by four independent physicians; investigation by the QA Committee and Credentials Subcommittee; an evidentiary hearing before the Fair Hearing Panel; and a review of the entire matter by the House Committee. The

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[8] Nicholas argues that the Colorado Supreme Court erred in not adopting the findings and conclusions of the CAC. However, the CAC is limited, by statute, to an eight-hour hearing on the *sole issue* of anticompetitive conduct. C.R.S. § 12-36.5-106. The findings and conclusions of the CAC are therefore not binding precedent under the theories of collateral estoppel or res judicata, and do not alter the requirement that the court rule upon HCQIA immunity as a matter of law.

Court noted that "Nicholas has introduced no evidence to suggest that NCMC did not make reasonable efforts to obtain the facts prior to the decision of the Board of Directors." (Petitioner's App. 22).

The Colorado Supreme Court also correctly concluded that NCMC complied with all notice and hearing procedures required by HCQIA. In particular, it held a Fair Hearing in which Nicholas was allowed, with the assistance of counsel, to call witnesses, offer exhibits and make argument in support of his position. Nicholas was informed as to his rights throughout the review, and was provided written decisions at all stages of the proceeding. Based upon these undisputed facts, the Court concluded "[t]here is no evidence in the record to suggest that Nicholas was not afforded adequate notice or was denied a fair hearing." (Petitioner's App. 23). Finally, the Court reached the proper conclusion that NCMC had a factual basis for its decision, based upon the voluminous materials, testimony, reports and exhibits reviewed by NCMC prior to making its decision.

The power of the Colorado Supreme Court to confer immunity upon NCMC is undisputed. This Court should therefore decline to review the Colorado Supreme Court's determination of HCQIA immunity based upon the lack of a compelling issue and because the Court properly applied federal law in reaching its conclusions.

CONCLUSION

Nicholas has failed to demonstrate a compelling issue upon which certiorari should be granted. At best,

he has argued that the Colorado Supreme Court misapplied the law in his case. As such, he has failed to advance any reason why this Court should grant certiorari.

Respondents therefore pray that this Honorable Court deny the Petition for Writ of Certiorari.

Respectfully submitted,

JEROME M. REINAN
2150 W. 29th Ave., 5th Floor
Denver, CO 80211
Telephone: (303) 894-0383
Fax number: (303) 894-0384
Counsel for Respondents

DISTRICT COURT, COUNTY OF WELD,
STATE OF COLORADO
Case No. 93 CV 329 Division I

ORDER GRANTING PARTIAL SUMMARY JUDGMENT IN FAVOR OF DEFENDANTS ON PLAINTIFF'S ELEVENTH CLAIM FOR RELIEF PURSUANT TO 42 U.S.C. § 1983

(Filed Dec. 4, 1997)

WILLIAM JOHN NICHOLAS,

Plaintiff,

v.

NORTH COLORADO MEDICAL CENTER, INC., a Colorado corporation, commonly referred to as NCMC, and its Board of Directors; Richard H. Stenner, its President; Karl B. Gills, its Executive Vice-President; Alyce Kantner, its former Director of Medical Services; Pat (Wilson) Kern, its director of Cardiovascular Services; and Defendants Doe 1 and 15,

Defendants.

THIS MATTER comes before the court on Defendant's Motion for Summary Judgment. In this Order, the Court will only address Plaintiff's Eleventh Claim for Relief under 42 U.S.C. § 1983.

This suit arises out of the suspension of Plaintiff, Dr. William John Nicholas, from certain hospital privileges at North Colorado Medical Center. The hospital suspended his privileges after a professional review process, which

included investigation by the hospital's Quality Assurance Committee, its House Subcommittee, its House Committee, and a Fair Hearing Panel. Nicholas is alleging that the members of these panels and certain other hospital administrators ousted him from the hospital without due process, in bad faith, and with an anticompetitive intent.

In order to bring a claim under 42 U.S.C. § 1983, the defendants' actions must qualify as "state action." Thus, the question here is whether the hospital's peer review process qualifies as "state action."

The *Berg* cases speaks directly to this issue. *Berg v. Shapiro*, 95 CA 1899 (Colo. App. Div. I), 1997 WL 184000 (April 17, 1997). In that case, the Court of Appeals held that professional peer review at a private hospital did not qualify as "state action" for purposes of 42 U.S.C. § 1983.

NCMC is a private, non-profit corporation. Thus, its actions are not "state actions" for purposes of 42 U.S.C. § 1983. Therefore, Plaintiff cannot bring a claim against Defendants pursuant to this statute.

The Court would like to note that the above analysis does not mean that Defendants' actions do not qualify for immunity under C.R.S. 12-36.5-101, et seq. or 42 U.S.C. § 11111, et seq. While the *Berg* court held that a private hospital's peer review action is not "state action" for purposes of § 1983, that same court indicated that professional peer review at a private hospital is "clothed with the status of a state agency" concerning issues of anticompetitive conduct under CRS 12-36.5-106. Thus, the immunity issues in this case are still alive and will be decided by the court at a later date.

IT IS ORDERED:

Plaintiff's eleventh claim for relief based on 42 U.S.C. § 1983 is DISMISSED with prejudice.

DATED: DEC 04 1997

/s/ William L. West
William L. West
District Court Judge

DISTRICT COURT, COUNTY OF WELD,
STATE OF COLORADO

Case No. 93 CV 329

ORDER

(Filed Jan. 17, 1998)

JOHN NICHOLAS, Plaintiff,

v.

NORTH COLORADO MEDICAL CENTER, INC., et. al., Defendant,

This matter comes before the Court on the Plaintiff's Motion to Reconsider the Court's Order Dismissing Plaintiff's § 1983 claim (Plaintiff's 11th Claim for Relief). Admittedly, the court did not address a number of Plaintiff's arguments in its short decision. The Court cited *Berg v. Shapiro* (Colo. App. 1997) 948 P.2d 59 (95 CA 1899), for the proposition that a private hospital's use of a peer review committee does not make the actions of the hospital state action for purposes of § 1983. At the time of the Court's Order, certiorari was pending in *Berg*. Since then certiorari has been denied, and is binding on this Court in the absence of any other state court decision.

The *Berg* case dealt with a private hospital. I did not discuss in my prior Order Plaintiff's argument that NCMC is a public hospital. The issue in this case is whether the denial of Dr. Nicholas' privileges was state action. In order for Plaintiff to establish his § 1983 claims he must show that Weld County exercises such dominion and control over the Hospital's physician credentialling

functions that the revocation of Dr. Nicholas's privileges constitutes state action.

It is not disputed that the Hospital is a private entity. Therefore, in order to assert a § 1983 claim the Plaintiff must show a nexus between the state and the challenged action sufficient to establish that the action should fairly be treated as that of the state. *Blum v. Yaretsky* (1982) 457 U.S. 991, 102 Sup. Ct. 2777. The conduct complained of must have been caused by the state's exercise of "coercive power" or must have been caused by the state's provision of "such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the state." *Blum*, 457 U.S. 1004, 102 Sup.Ct. 2786.

In *Lo-Seng Yo v. Cibola General Hospital*, (10th Cir. 1983) 706 F2d 306, the court held that probationary sanctions against a doctor did not constitute state action. The court also noted that the hospital's receipt of government funds for construction and operation plus the fact that the hospital was the only hospital within a 60-mile radius were insufficient facts to establish state action. Rather, a substantial nexus must exist between the governmental control alleged and the specific conduct which purportedly constitutes state action.

Tunca v. Lutheran General Hospital (7th Cir. 1988) 844 F2d 411, involved the termination of a doctor's privileges and the Court held that mere ownership of the hospital's land by the county was insufficient to establish state action. As in the instant case, the lease between the county and the hospital did not reserve to the county any right to exercise any management or operational control over the hospital.

The presence of public officials, or the appointment of members to the board of directors of the hospital, does not render decisions of the board state action. *Crowder v. Conlan* (6th Cir. 1984) 740 F2d 447. In Crowder, the court held that the facts that the county owned the facility, provided financing for the construction, and had two public officials on the board were insufficient to establish a nexus between the state and the hospital in regard to its credentialling decisions.

Having reviewed the voluminous materials provided by both parties, I conclude that NCMC was a private hospital and that the County did not retain or exercise any control over the operations and management of the Hospital, and particularly with regard to the Hospital's credentialling decisions.

Plaintiff relies on cases that have applied a "Public Function" test. *Milo v. Cushing Memorial Hospital* (10th Cir 1988) 861 F2d 1194; *Carnes v. Parker* (10th Cir. 1991) 922 F2d 1506; *Moore v. Wyoming Medical Center* (D. Wyo. 1993) 825 F. Supp. 1531; *Burton v. Wilmington Parking Authority* (1961) 356 U.S. 715. Plaintiff's reliance on these cases is misplaced. They all assume that the hospital involved had a pre-existing relationship with the county sufficient to find that the hospital acted in the place of the county. Those are not the facts of the instant case. Rather, in the instant case the County and the Hospital are independent entities, neither having the ability to control the other.

Further, the public function test considers three questions: 1) whether the County receives a direct financial benefit from the lessee, 2) whether the County benefited from the action complained of, and 3) whether the

County retained control of and responsibility for the Hospital. There is no evidence that the County benefited from the restriction of Dr. Nicholas's privileges. The Plaintiff argues that one reason for his discipline was that he did not keep patients in the hospital long enough, thereby depriving the Hospital of income. Without commenting on the strength of that argument, it does not address how the County might benefit. The loss of income may affect the profits of the Hospital, but it does not affect the County.[1]

The third question is also answered in the negative. The County has not retained or exercised any control over the Hospital.

In addition, the cases cited by Plaintiff can be factually distinguished from the instant case.

For the reasons set forth,

IT IS ORDERED:

The Motion for Reconsideration is denied.

Dated: January 17, 1998

/s/ William L. West
William L. West
District Court Judge

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[1] Under the lease, if gross income of the Hospital was sufficiently affected, it could conceivably affect the Hospital's rent payment. Besides being highly speculative, it is highly unlikely.

EXHIBIT "A"

DISTRICT COURT, COUNTY OF WELD,
STATE OF COLORADO

Case No. 93 CV 329

FINDINGS OF FACT, CONCLUSIONS OF LAW, AND ORDER

(Filed JUN. 05, 98)

JOHN NICHOLAS, Plaintiff,

v.

NORTH COLORADO MEDICAL CENTER, INC.; RICHARD H. STENNER; KARL B. GILLS; ALYCE KANTNER; PAT (WILSON) KERN; and Defendants Doe 1-15, Defendants,

This matter came on for hearing on Defendants' Motion for Summary Judgment on Immunity January 26, 1998 through February 6, 1998. The Plaintiff appeared by Philip A. Nicholas, Esq., W. J. Nicholas, Esq., and Jason Tangeman, Esq. Defendants appeared by Jay M. Reinan, Esq. The Court heard the testimony, received the exhibits, heard the arguments of counsel, and took the matter under advisement. The Court has received both parties' closing briefs.

I

Background

Plaintiff is a licensed physician specializing in cardiology. He came to Greeley in approximately 1989 and

received credentials to practice at North Colorado Medical Center (NCMC). In 1992, the Board of Governors of NCMC revoked his level three privileges to practice invasive cardiology. Plaintiff then filed a complaint under C.R.C.P. 106 for judicial review of the Hospital's administrative decision. (92 CV 447). At the same time, the Plaintiff appealed the Hospital's revocation of Plaintiff's level three privileges to the State Board of Medical Examiners Committee on Anticompetitive Conduct pursuant to CRS 12-36.5-106(7). Proceedings in 92 CV 447 were stayed pending the decision of the State Committee. The Complaint in the instant action was filed July 2, 1993. On July 12, 1993 the State Committee reversed the Hospital Board's decision and ordered Plaintiff's privileges reinstated. That decision was affirmed by the Court of Appeals (*Nicholas v. Northern Colorado Medical Center, Inc.* (Colo.App. 1995) 902 P2d 462) and the Supreme Court (*North Colorado Medical Center, Inc. v. Committee on Anticompetitive Conduct* (Colo.1996) 914 P2d 902). The 92 CV 447 case was dismissed on October 7, 1996.

In the present action, the Third Amended Complaint set fourth [sic] 15 claims for relief. First, Declaratory Judgment; Second, Injunctive Relief; Third, Negligence; Fourth, Breach of Contract; Fifth, Wilful Breach of Contract; Sixth, Defamation; Seventh, Intentional Infliction of Mental Suffering; Eighth, Tortious Interference With Contract; Ninth, Fraud and Misrepresentation; Tenth, breach of Duty of Good Faith and Fair Dealing; Eleventh, Violation of Civil Rights under 42 USC 1983; Twelfth, Anticompetitive Conduct; Thirteenth, Outrageous Conduct; Fourteenth, Abuse of Process; Fifteenth, Arbitrary, Capricious and Unreasonable Conduct.

Several of these claims are no longer at issue. By Order dated October 7, 1996, the Court dismissed the Claims for Declaratory Judgment and Injunctive Relief. By Order dated December 4, 1997, the Court dismissed the §1983 Claim. During the course of the Hearing on Immunity, the Plaintiff voluntarily dismissed the action against Richard Stenner and Pat Kern. In addition, the appeal to the State Committee on Anticompetive Conduct provides the exclusive remedy for Plaintiff's Twelfth Claim for Relief.

II

Nature of the Hearing

Defendants moved for Summary Judgment on the remaining claims on the grounds that they are immune from suit and liability under The Colorado Professional Review Act CRS 12-36.5-101 *et seq.* and the Federal Health Care Quality Improvement Act 42 USC 11111 *et seq.* Immunity is a question of law to be decided by the court. *Trinity Broadcasting v. Westminster* (Colo.1993) 898 P2d 916, 924; *Bryan v. Holmes Regional Med. Ctr.* (11th Cir. 1994) 33 F3d 1318, 1332.[1] During the course of the hearing the Plaintiff acknowledged that he was not challenging the actions or conduct of the Quality Assurance Committee, the Credentials Committee, or the Fair Hearing

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[1] Under section 105 of the Colorado Act, immunity presents an issue of subject matter jurisdiction under CRCP 12(b). Under the Federal Act, the Court must first determine whether the Plaintiff has overcome the presumption. If the Court determines that has met the minimum standards of the Act, summary judgment is appropriate.

Panel.[2] The federal and state acts are similar in some respects, but they are not identical. Both have as their purposes the assurance of quality health care, the protection of people from unprofessional conduct, and the protection of those people who participate in professional peer review activities. In one section, the Colorado Act provides immunity from suit. CRS 12-36.5-105. In another section, it provides immunity from damages. CRS 12-36.5-203. On the other hand, the Federal Act provides a rebuttable presumption of immunity from damages. The Colorado Act does not contain any such presumption, *North Colorado Medical Center v. Committee on Anti-competitive Conduct, supra,* although the Governing Board's decision is entitled to a presumption of validity and regularity. Both the Federal Act and §203 of the Colorado Act require the participants in the review process to act reasonably. In addition, section 105 of the Colorado Act requires the participants to act in "good faith." Both acts require that the professional review activities be conducted in accord with certain procedural guidelines.

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[2] Plaintiff stated he was not arguing bad faith. He was not saying anyone had an evil motive. He was not challenging the actions of the Credentials Subcommittee, he was not challenging the actions of the Fair Hearing Panel. He was only challenging the action of the House Committee and the Board of Directors.

III

The Statutes

A. The Colorado Professional Review of Health Care Providers Act. CRS 12-35.5-101 *et seq.* (PRHCP)

Section 105(1) of the PRHCPA provides immunity from suit to any person who participates in the professional review process so long as such person made a reasonable effort to obtain the facts of the matter, acted in the reasonable belief that the action was warranted by the facts, and otherwise acted in good faith. Section 105(2) provides immunity from suit for damages to the governing board and its individual members and to the entity so long as they act in good faith.

"Good faith" includes reliance on the recommendations of the review committee and requires consideration of any facts not previously available to the peer review committee and that the board act in the reasonable belief that the action taken was warranted by the facts.

"Governing Board" means any governing body or duly authorized subcommittee with final authority under written bylaws, policies, or procedures to take final action regarding the recommendation of any authorized review committee. §12-36.5-102(2).

"Professinoal Review Committee" means any committee authorized under the provisions of this article to review and evaluate the professional conduct and quality of practice of a licensed physician. §12.36.5-102(3).

"Records" includes any and all written or verbal communications by any person, professional review committee, governing board, or staff arising from the activities of a professional review committee.

CRS 12-36.5-104(2) provides that a professional review committee must be composed of a majority of physicians.[3] Subsection (7) provides certain minimum requirements: (a) the physician is entitled to a hearing, (b) a person who was a member of the investigating committee may not be a member of the hearing committee, (c) the physician has a right to reasonable notice, right to be present, right to be represented by counsel, and the right to offer evidence, (d) the hearing committee shall make recommendations to the governing board, and (e) the physician must be given a copy of the recommendations, and shall have a right to appeal the findings and recommendations to the governing board. Subsection (8) provides that the governing board must adopt written bylaws, policies or procedures that provide for a right of appeal, reasonable notice, right to counsel, and the right to appear and offer argument. The bylaws may provide that the appeal be heard by a committee of the governing board.

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[3] There appears to be an exception created for committees created by governing boards that have a professional review committee established pursuant to article 36 of title 12. There is no current reference to professional review committees in article 36 that I can find.

B. CRS 12-36.5-201 *et seq.*

Section 201 essentially adopts the Federal Health Care Quality Improvement Act of 1986, discussed later. It provides immunity from damages for virtually everyone involved in a professional review action, so long as the action taken relates to the competence or professional conduct of a physician.

C The Federal Health Care Quality Improvement Act of 1986. 42 USC §11111, *et seq.* (HCQIA)

Although the chapter of the U.S.C. containing the Federal Act is entitled "Encouraging Good Faith Professional Review Activities," the Federal Act does not actually use the term "Good Faith." It provides broad immunity for persons involved in professional review activity so long as certain standards are met. Section 1112(a) provides that the professional review action must be taken (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts, (3) after adequate notice and fair hearing procedures are afforded the physician, and (4) in the reasonable belief that the action was warranted by the facts. Subsection (b) specifies the notice and hearing requirements, which are substantially the same as required by the Colorado statute.

IV

NCMC Procedures

There are essentially three groups associated with the operation of the hospital: the Board of Directors, the

Administration, and the Medical Staff. The Board of Directors is the governing board and is at the top of the organizational chart. It appoints the President and CEO, who is in charge of the administration. The Chief of the Medical Staff is elected by the Medial Staff. The Medical Staff has bylaws that govern review of patient charts and care and a Quality Assurance Committee that reviews complaints and charts appearing to reflect deficiencies or variances from the norm.[4] The Quality Assurance Committee performs some review and investigation and, if it determines that there is a problem with a physician, it makes recommendations to the Credentials Subcommittee. The Credentials Subcommittee is charged with the responsibility of investigating and making recommendations regarding whether new physicians will be accepted to practice in the hospital and whether physicians already on staff will have privileges suspended, revoked, or limited in some other manner. If a physician receives an adverse finding or recommendation from the Credentials Subcommittee, he or she may request a hearing before a "Fair Hearing Panel," pursuant to the hospitals Corrective Action/Fair Hearing Plan. Under the Plan, either the physician or the Credentials Subcommittee may appeal the findings and recommendations of the Fair Hearing Panel to the House Committee. The House Committee makes its recommendations to the Board of Directors, which makes the final decision and takes the final action.

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[4] The Medical Staff bylaws refer to the Quality Assessment Committee. During the hearing it was consistently referred to as the Quality Assurance Committee.

The Administration supplies staff to support all of the various committees. The Quality Assurance Committee is made up primarily of physicians.[5] It may have one member of the Board of Directors, although it did not during the investigation of the Plaintiff. It may also contain members from the Administration. The Medical Staff members must constitute a majority of the voting members. The Credentials Subcommittee is appointed by the House Committee and is made up of eight physicians representing each of the Hospital departments, one member from the House Committee, and one member of the Administration. In this case, the House Committee member was also a physician. The House Committee is appointed by and made up of members of the Board of Directors. The Board of Directors appoints its own members. It contains representatives from the community, physicians, and the President/CEO, who is a ex officio member.

V

Facts

Plaintiff joined the NCMC staff in August 1989. In 1990 the Quality Assurance Committee received one or more reports of incidents or variances that caused the QA Committee to review a number of medical charts of Plaintiff's patients. The QA Committee initially recommended that Plaintiff be proctored by for a period of time. Dr. Marsh, the proctoring doctor, reported in December of

[5] The vice-chair of each of the hospitals 8 medical departments.

1990 that he felt that Plaintiff was competent to continue without further proctorship. Previously, Dr. Marsh who was head of the Cath Lab, had suspended Plaintiff's Cath Lab privileges. However, the QA Committee continued to have concerns and decided to have an outside review performed. The review, which was conducted by Dr. G. David Jang, was critical of Plaintiff.[6] Following Dr. Jang's report and after giving Dr. Nicholas an opportunity to reply to the report, the QA Committee reported to the Credentials Subcommittee and offered three options:

1. Suspend Dr. Nicholas' invasive cardiology privileges until the resolution of all QA concerns,

2. Enroll Dr. Nicholas in a one-year training course in invasive cardiology at an accredited training program, or,

3. Obtain an independent evaluation from a Colorado cardiologist, Roy Thompson, M.D., to evaluate the appropriateness of onsite proctoring versus formal retraining.

The QA Committee ultimately recommended the third option.

Then, the Credentials Subcommittee met and discussed the report of the QA Committee. Dr. Nicholas was allowed to address the Subcommittee regarding the recommendations and the quality assurance issues. The Subcommittee concluded that allowing Dr. Nicholas to continue with invasive cardiology privileges posed a risk to patient health, safety, and welfare and threatened to

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[6] A copy of Dr. Jang's report was furnished to Dr. Nicholas as soon as it was received.

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interfere with the medical center's ability to provide quality patient care.[7] Based on this conclusion, the Subcommittee directed the president of the Hospital to summarily suspend Dr. Nicholas' invasive cardiology privileges, pending further investigation and review by the Subcommittee. Richard Stenner, the president, notified the Plaintiff of the suspension by letter the same day.

Over the following couple of weeks the Subcommittee interviewed several doctors and nurses and hired three additional doctors to conduct reviews of certain of Dr. Nicholas's patient charts. Those reviews were also critical of Dr. Nicholas. Following receipt of these reports, Dr. Nicholas individually contacted each of the reviewing doctors and represented that because of their reports, his privileges were being revoked. He also furnished information outside of his charts and patient notes. As a result of Dr. Nicholas's contact, the doctors softened their criticisms to some degree.

The Credentials Subcommittee, after receiving Dr. Nicholas's responses to the outside reviews, found that Dr. Nicholas was deficient in a number of categories. Based on those findings, the Credentials Subcommittee determined to suspend Dr. Nicholas's invasive cardiology privileges.

Pursuant to the by-laws and the corrective action plan, Dr. Nicholas was provided with notice of his right to request a Fair Hearing.

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[7] The Subcommittee made a number of factual findings leading up to its conclusion. The record supports the Subcommittee findings and its conclusion.

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Subsequently, a Fair Hearing Panel was appointed and a hearing was held. The Fair Hearing Panel found that Dr. Nicholas had a number of deficiencies. Of particular note, the Panel found:

> 11. Nicholas lacks insight into the purpose and process of creating a valid and useful medical record. He operates under the false impression that detailed dictation of the procedure notes substitutes for current and complete entries in the progress notes. Nicholas' paucity of initial documentation in the progress notes and his constant need to recreate the record in light of new findings leads the panel to the conclusion that he had a definite inability to form a rational treatment plan based on a logical progression of thought. His entries in the progress notes are inadequate to communicate his reasoning and treatment plan without additional information to nurses and other professionals. This continuing deficiency is, in out [sic] opinion, at the root of Nicholas' problems as it causes others to perceive (a) a lack of judgment, (b) a lack of planning or coherent treatment plan, (c) the use of unnecessary or unindicated treatment and (d) unethical behavior.
>
> 17. That Nicholas seems to now recognize his responsibility for any technical and judgmental errors or deficiencies. Nicholas continues, however, to lack insight into his documentation deficiencies and their impact on patient care or interpersonal and interprofessional relationships.
>
> 18. That the summary suspension of the cardiac catheterization laboratory privileges by the Credentials Subcommittee was reasonable and

appropriate in light of the information available to it.

The Hearing Panel then made recommendations that Dr. Nicholas be closely supervised and monitored and that if he continued to evidence deficiencies that his privileges be modified, limited or revoked.

Both Dr. Nicholas and the Credential Subcommittee appealed to the House Committee. The House Committee considered the Report of the Fair Hearing Panel, together with the Credential Subcommittee Report. The record before the Fair Hearing Panel included the Credential Subcommittee's Report, reports from the Quality Assurance Committee, and the reports of Drs. Jang, Greenberg, Molk, and Cohen.

The House Committee determined that the findings of the Fair Hear Panel and those of the Credential Subcommittee, although worded differently were substantially similar.[8] The House Committee agreed with the Credentials Subcommittee that the deficiencies were more serious than perceived by the Fair Hearing Panel and recommended more stringent sanctions. Rather than allowing Dr. Nicholas to continue invasive cardiology under supervision, the House Committee recommended that his invasive privileges be revoked and that he be placed on probation for a year. The recommendation left open the possibility that Dr. Nicholas could re-apply for invasive cardiology privileges. The Board of Directors ratified the House Committee recommendations.

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[8] The House Committee did not find that Dr. Nicholas had been untruthful or that he lacked candor.

VI

Conclusions

As earlier noted, Plaintiff does not challenge any of the actions taken, except the actions of the House Committee and the Board of Directors, which Plaintiff challenges on the basis of procedural errors and noncompliance with the immunity statutes.

I conclude that the policies and by-laws of NCMC substantially comply with both the provisions of CRS 12-36.5-101 et seq. and with 42 USC 11101 et seq. I further conclude that the hospital substantially complied with its by-laws and requirements and with the requirements of both the federal and statute [sic] statutes.

I conclude that the fact members of the House Committee were also members of the Credential Subcommittee does not violate either statute.

A.

I conclude that CRS 12-35.5-105(1) provides immunity from suit for all participants in the professional review process. I conclude and find by a preponderance of the evidence that Karl Gills and Alyce Kantner acted in good faith. The evidence persuades me that their primary concern was the welfare of patients of the hospital. Plaintiff attempts to infer that Ms. Kantner was acting in bad faith because she wanted Dr. Nicholas out of the hospital. It may be true that she wanted Nicholas out, but she was privy to information that would justify that belief. In addition, Plaintiff presented no evidence that she supplied false or misleading information. The evidence about

the "altered film" was not entirely clear. Counsel for Plaintiff seems to assert that Ms. Kantner received a film with blue writing on it. However, Dr. Nicholas testified that he wrote in blue ink on a copy of the film and then made a photocopy of that to deliver to Ms. Kantner. Therefore, the copy Kantner received was entirely black and white. In any event that was not a matter of import in the final analysis.

I'm hard put to find any evidence that Karl Gills did not act in good faith. He may have delivered some documents outside the charts and patient notes to the independent review doctors in Denver, but by itself that is not bad faith. There was more than sufficient evidence to show that Gills and Kantner acted in the reasonable belief that their actions were warranted by the facts.

CRS 12-36.5-105(2) provides immunity "from suit for any damages in a civil or criminal action. . . . " (emphasis added) I reject Plaintiff's argument that this section grants only immunity from liability. The statute is clear, unambiguous and immunity from suit is consistent with the purposes of the statute.

Plaintiff assumes that an appeal from the Fair Hearing Panel is like an appeal from a trial to an appellate court; that the governing board is bound by the facts and conclusions of the Panel and cannot go beyond that. I disagree. The Fair Hearing procedure is to make sure that the Doctor has a full opportunity to develop his position. The Fair Hearing Panel does not make a "decision" that the governing board must either accept or reject. It makes a recommendation. I conclude that the statute leaves to the governing board the ultimate authority as to what

action should be taken. Further, I conclude that in making its decision the Board is not limited to either to [sic] the findings of fact or the recommendation of the Fair Hearing Panel.

In this case, however, the governing board did not reject the findings of the Fair Hearing Panel. Rather, based on those findings, the Board reached a different result. I conclude that while the House Committee and the Board are required to consider the Fair Hearing Panel Report, they are not prohibited from considering other information, so long as Dr. Nicholas had notice and opportunity to respond. Dr. Nicholas had such an opportunity at all stages of the proceedings. I conclude and find by a preponderance of the evidence that the House Committee and the Board acted in good faith. Further, I conclude that they relied on the recommendations of a professional review committee, albeit it [sic] the Credentials Subcommittee, and that there is no evidence that any member had knowledge that made such reliance unwarranted. Further, I find by a preponderance of the evidence that the House Committee and Board acted in the reasonable belief that the action taken was warranted by the facts.

I conclude that the fact that Ken Lind was on the Board of Directors, the House Committee and the Credential Subcommittee does not violate the statutes nor impair the validity of the proceedings.

The parties have devoted some time to whether "good faith" is determined by a subjective or objective test, and who has the ultimate burden of proof. I don't

resolve those issues. Under either a subjective or objective test, and regardless of who has the burden of proof, I find by a preponderance of the evidence that Defendants individually and collectively acted in good faith.[9]

B.

The Federal Act provides immunity for damages for virtually all participants in the peer review process.[10] Immunity under the Federal Act is clearer than under the State statute. If there is compliance with section 1112(a) then the participants are not liable in damages. In addition, no person who supplies information shall be liable unless such information is false and the person providing it knew that such information was false.

Section 11112((a) [sic] requires that the action must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician . . . , (4) in the reasonable belief that the action was warranted by the facts. . . .

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[9] Although I don't decide the issues, my inclination is that good faith under Section 105 of the Colorado Statute means subjective good faith, and that Defendant bears the burden of proving good faith. I believe the standard under the Federal Act is objective good faith and that Plaintiff bears the burden of overcoming the presumption.

[10] As noted, the only claims remaining are damage claims.

Even without the presumption contained in the statute, the evidence establishes by a preponderance of the evidence that Defendants met each of the four criteria. In addition I agree with Defendant that *Bryan v. James E. Homes Regional Medical Center* (11th Cir. 1994) 33 F3d 1318 is directly in point and resolves most, if not all, of Plaintiff's procedural objections.

VII

Summary

Essentially the plaintiff argues that the hospital is not entitled to immunity because (1) the investigatory and adjudicatory functions were intermingled; and, (2) because the House committee and Board considered the reports of the Quality Assurance Committee and the Credentials Subcommittee. As previously noted I find that both the QA Committee and the Credentials Subcommittee meet the requirements of the statute as an authorized Professional Review Committee. Pursuant to CRS 35-5-102 the governing board may "take final action regarding the recommendations of any authorized professional review committee." My view of the statute, as a whole and considering its purposes, is that the Board of Directors may appoint an authorized professional review committee. I believe that the construction is even more clear with regard to the Federal Act and section 203 of the Colorado Act.

In summary, I find that Dr. Nicholas received the minimum procedural and substantive due process rights required by the statutes. I find that the fact that members of the Board and House Committee were also on the

Credentials Subcommittee did not deprive Plaintiff of due process.

By definition the findings and recommendations of the Fair Hearing Panel are not a "decision." The Fair Hearing Panel makes *recommendations*. The "appeal" is not an appeal in the traditional sense in which an appellate court reviews the record and either accepts or rejects a trial court decision. Rather, the House Committee makes a final decision, subject to ratification by the Board of Directors, based on the findings and recommendations of the Fair Hearing Panel. Had the House Committee and Board rejected the findings of the Fair Hearing Panel a different issue would be presented. In this case, however, the House committee accepted the findings. It reached a different result only with regard to the corrective action. This does not impugn good faith.

The Board of Directors has the ultimate responsibility for ensuring that patients receive competent and quality health care (not to mention avoiding potential mal-practice actions). The totality of the evidence persuades me by a preponderance of the evidence that the Board acted in good faith in the interests of the public health and safety.

I conclude that Defendants are immune from liability for damages under the Federal statute. It follows from this that Defendants are immune from liability for damages under §203 of the Colorado Act.

VIII

Judgment and Order

Defendant's Motion for Summary Judgment is granted and this action is dismissed, with prejudice.

IT IS ORDERED:

The trial set to begin October 13, 1998 is vacated.

Plaintiff's Motion to Set Aside Summary Judgment Dismissing Plaintiff's 1983 Claim (11TH Claim) is DENIED.

Plaintiff's Motion to Amend the Finding of the Court's December 4, 1997 and January 17, 1998 Orders is DENIED.

Plaintiff's Motion to Revisit and Reconsider the Defendant's Motion for Summary Judgment is DENIED.

Plaintiff's Motion to Grant Leave to Supplement the Plaintiff's Responses to the Motions and this Motion is DENIED.

Plaintiff's Motion to Defer Final Rulings and Orders until the Hospital has Fully Responded to Outstanding Discovery Requests is DENIED.

Plaintiff's Motion to Grant Partial Summary Judgment in Plaintiff's Favor Concerning the Defendant's 1983 Liability is DENIED.

Defendant's Motion to Strike is DENIED.

Plaintiff's Motion to Fix Time to Respond is MOOT.

All other outstanding motions are either moot or denied.

Dated: June 5, 1998

/s/ William L. West
William L. West
District Judge

ARTICLE 36.5

Professional Review of Health Care Providers

PART I

PROFESSIONAL REVIEW PROCEEDINGS - PHYSICIANS

12-36.5-101. Legislative declaration.

12-36.5-102. Definitions.

12-36.5-103. Use of professional review committees.

12-36.5-104. Establishment of professional review committees – function.

12-36.5-105. Immunity from liability.

12-36.5-106. Committee on anticompetitive conduct.

PART 2

CONFORMANCE WITH FEDERAL LAW AND REGULATION

12-36.5-201. Legislative declaration.

12-36.5-202. Rules and regulations – compliance with reporting requirements of federal act.

12-36.5-203. Limitations on liability relating to professional review actions.

PART I

PROFESSIONAL REVIEW PROCEEDINGS - PHYSICANS

12.36.5-101. Legislative declaration. (1) The general assembly hereby finds, determines, and declare that the

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Colorado state board of medical examiners created pursuant to article 36 of this title acts for the state in its sovereign capacity to govern licensure, discipline, and professional review of persons licensed to practice medicine in this state. The general assembly further finds, determines, and declare that the authority to practice medicine in this state is a privilege granted by the legislative authority of the state and that it is necessary for the health, safety, and welfare of the people of this state that the board of medical examiners exercise its authority to protect the people of this state from the unauthorized practice of medicine and from unprofessional conduct by persons licensed to practice medicine under article 36 of this title.

(2) The general assembly recognizes that: Many patients of persons licensed to practice medicine in this state have restricted choices of physicians under a variety of circumstances and conditions; many patients lack the knowledge, experience, or education to properly evaluate the quality of medical practice or the professional conduct of those licensed to practice medicine; and it is necessary and proper that the board of medical examiners exercise its regulatory authority to protect the health, safety, and welfare of the people of this state.

(3) The general assembly recognizes that, in the proper exercise of its authority and responsibilities under this article, the board of medical examiners must, to some extent, replace competition with regulation and that such replacement of competition by regulation particularly with regard to physicians, is related to a legitimate state interest in the protection of the health, safety, and welfare of the people of this state.

12-36.5-102. Definitions. As used in this article, unless the context otherwise requires:

(1) "Board of medical examiners" means the Colorado state board of medical examiners created pursuant to section 12-36-103.

(2) "Governing board" means any board, board of trustees, governing board, or other body, or duly authorized subcommittee thereof, of any organization of health care providers, which board or body has final authority pursuant to such organization's written bylaws, policies, or procedures to take final action regarding the recommendations of any authorized professional review committee.

(3) "Professional review committee" means any committee authorized under the provisions of this article to review and evaluate the professional conduct of and the quality and appropriateness of patient care provided by any physician licensed under article 36 of this title.

(4) "Records" means any and all written or verbal communications by any person, any member of an investigative body, or any professional review committee or governing board, or the staff thereof, arising from any activities of a professional review committee authorized by this article, including the complaint, response, correspondence related thereto, recordings or transcripts of proceedings, minutes, formal recommendations, decisions, exhibits, and other similar items or documents typically constituting the records of administrative proceedings.

12-36.5-103. Use of professional review committees. (1) The general assembly recognizes that the board of medical examiners, while assuming and retaining ultimate authority for licensure and discipline in accordance with article 36 of this title and in accordance with this article, cannot practically and economically assume responsibility over every single allegation or instance of purported deviation from the standards of quality for the practice of medicine, from the standards of professional conduct, or from the standards of appropriate care and that an attempt to exercise such oversight would result in extraordinary delays in the determination of the legitimacy of such allegations and would result in the inappropriate and unequal exercise of its authority to license and discipline physicians. It is therefore the intent of the general assembly that the board of medical examiners utilize and allow professional review committees and governing boards to assist it in meeting its responsibilities under article 36 of this title and under this article.

(2) All physicians are encouraged to serve upon such professional review committees when called to do so and to study and review in good faith the professional conduct of physicians, including the quality and appropriateness of patient care.

(3)(a) The use of professional review committees is declared to be an extension of the authority of the board of medical examiners. However, except as otherwise provided in this article, nothing in this article shall limit the authority of professional review committees properly constituted under this article.

(b) Professional review committees, the members who constitute such committees, governing boards, and persons who participate directly or indirectly in professional review proceedings are granted certain immunities from liability arising from actions which are within the scope of their activities and taken in good faith as provided in section 12-36.5-105. Such grants of immunity from liability are declared to be necessary to ensure that professional review committees and governing boards can exercise their professional knowledge and judgment.

12-36.5-104. Establishment of professional review committees – function. (1) A professional review committee may be established pursuant to this section to review and evaluate the quality and appropriateness of patient care provided by and the professional conduct of any physician licensed under article 36 of this title.

(2) Persons licensed to practice medicine under article 36 of this title who are actively engaged in the practice of medicine in this state shall constitute a majority of any professional review committee established pursuant to this section, except for those boards authorized by paragraph (g) of subsection (4) of this section.

(3) A utilization and quality control peer review organization, as defined pursuant to 42 U.S.C. sec. 1320c-1, or any other organization performing similar review services under federal or state law shall be an approved professional review committee under this article.

(4) Any professional review committee established by any of the following organizations, entities, or professional societies shall be an approved professional review committee under this article if it operates pursuant to written bylaws, policies, or procedures which are in compliance with this article and which have been approved by its governing board:

(a) The medical staff of a hospital licensed pursuant to part 1 of article 3 of title 25, C.R.S., or certified pursuant to section 25-1-107 (1)(l)(II), C.R.S.;

(b) The medical staff of a hospital-related corporation. For the purposes of this paragraph (b), a corporation is "hospital-related" if the licensed or certified hospital or holding company of such hospital has ownership or control of such corporation.

(c) A society or association of physicians whose membership includes not less than one-third of the doctors of medicine or doctors of osteopathy licensed to practice and residing in this state, if the physician whose services are the subject of the review is a member of such society or association;

(d) A society or association of physicians licensed to practice and residing in this state and specializing in a specific discipline of medicine, whose society or association has been designated by the board of medical examiners as the specialty society or association representative of physicians practicing such specific discipline of medicine, if the physician whose services are the subject of the review is a member of such specialty society or association;

(e) An individual practice association or a preferred provider organization comprised of at least twenty-five physicians or a medical group which predominantly serves members of a health maintenance organization licensed pursuant to article 17 of title 10, C.R.S. A professional review committee established pursuant to this paragraph (e) shall have jurisdiction to review only physicians who are members of the association or organization creating and authorizing that committee; except that such professional review committee may review the care provided to a particular patient referred by a member of such association or organization to another physician who is not a member of such association or organization.

(f) A Colorado corporation authorized to insure physicians pursuant to article 3 of title 10, C.R.S., or any other corporation authorized to insure such physicians in this state when designated by the board of medical examiners under subsection (5) of this section;

(g) Governing boards of any entity which has a professional review committee established pursuant to article 36 of this title;

(h) Any peer review committee established or created by a combination or pooling of any of the organizations authorized by this section to have a professional review committee;

(i)(I) A nonprofit corporation or association comprised of representatives from a statewide medical society and a statewide hospital association. Such association shall be comprised of physicians, hospital administrators, and hospital trustees, with a majority of such representatives being physicians. The association may establish, or

contract for, one or more peer review committees to review the care by hospital staff physicians, with priority given to small rural medical staffs. Such peer review services shall be available statewide on a fee-for-service basis to licensed or certified hospitals at the joint request of the governing body and the medical staff of the hospital or at the sole request of the governing body of the hospital. If a physician being reviewed specializes in a generally recognized specialty of medicine, at least one of the physicians on the peer review committee shall be a physician practicing such specialty.

(II) For purposes of the introductory portion to this subsection (4), the bylaws, policies, and procedures shall be in compliance with this article and be approved by the nonprofit corporation or association.

(5) The board of medical examiners may establish by rule or regulation procedures necessary to authorize other health care or physician organizations or professional societies to establish professional review committees.

(6) a professional review committee acting pursuant to this part I may investigate or cause to be investigated: The qualifications of any physician licensed under article 36 of this title who seeks to subject himself to the authority of any organization, entity, or professional society listed in subsection (4) of this section; or the quality or appropriateness of patient care rendered by or the professional conduct of any physician licensed under article 36 of this title who is subject to the authority of such organization, entity, or professional society. Such investigation shall be conducted in conformity with written bylaws,

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policies, or procedure adopted by such organization, entity, or professional society.

(7) The written bylaws, policies, or procedures of any professional review committee shall provide for at least the following:

(a) If the findings of any investigation indicate that the physician who is the subject of the investigation is lacking in qualifications, has provided substandard or inappropriate patient care, or has exhibited inappropriate professional conduct, the professional review committee shall hold a hearing, unless the physician waives his right to a hearing, to consider the findings: except that, if the professional review committee is submitting its findings to another professional review committee for review, only one hearing shall be necessary prior to any appeal before the governing body.

(b) Any person who has participated in the course of any investigation shall be disqualified as a member of the committee at any hearing held pursuant to paragraph (a) of this subsection (7), but such person may participate as a witness in such hearing.

(c) The physician who is the subject of any investigation shall be given reasonable notice of such hearing and shall have a right to be present, to be represented by legal counsel at such hearing, and to offer evidence in his own behalf.

(d) After such hearing, the professional review committee shall make any recommendations it deems necessary to the governing board unless provided by federal law or regulation.

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(e) A copy of such recommendations shall be given to the subject physician who then shall have the right to appeal the findings and recommendations of the professional review committee to the governing board to which the recommendations are made.

(8)(a) All governing boards shall adopt written bylaws, policies, or procedures which provide that a physician who is the subject of an adverse recommendation by a professional review committee may appeal to the governing board. Such bylaws, policies, or procedures shall provide that the physician shall be given reasonable notice of his right to appeal and, unless waived by the physician, shall have the right to appear before the governing board, to be represented by legal counsel, and to offer such argument on the record as he deems appropriate.

(b) The bylaws may provide that a committee of not fewer than three members of the governing board may hear the appeal. Such bylaws may also allow for an appeal to be heard by an independent third party designated by the board.

(9) All governing boards which are required to report their final actions to the board of medical examiners are not otherwise relieved of such obligations by virtue of any provision of this article.

(10)(a) The records of a professional review committee, a governing board, or the committee on anticompetitive conduct shall not be subject to subpoena or discovery and shall not be admissible in any civil suit brought against a physician who is the subject of such records.

(b) Notwithstanding the provisions of paragraph (a) of this subsection (10), such records shall be subject to subpoena and available for use:

(I) By the committee on anticompetitive conduct;

(II) By either party in any appeal or de novo proceeding brought pursuant to this part 1;

(III) By a physician in a suit seeking judicial review of any action by the governing board;

(IV) By a governing board seeking judicial review.

(11) At the request of the board of medical examiners, a governing board shall provide the board of medical examiners with the complete record of all professional review proceedings, including, but not limited to, the findings, recommendations, and actions taken.

(12) Investigations, examinations, hearings, meetings, or any other proceedings of a professional review committee or governing board conducted pursuant to the provisions of this part 1 shall be exempt from the provisions of any law requiring that proceedings he conducted publicly or that thc minutes or records be open to public inspection.

(13) All proceedings, recommendations, records, and reports involving professional review committees or governing boards shall be confidential.

(14) a professional review committee or governing board which is constituted and conducts its reviews and activities pursuant to the provisions of this part I is

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declared not to be an unlawful conspiracy in violation of section 6-4-102, C.R.S.

12-36.5-105. Immunity from liability. (1) A member of a professional review committee, a witness before a professional review committee, or any person who files a complaint or otherwise participates in the professional review process shall be immune from suit in any civil or criminal action, including antitrust actions, brought by a physician who is the subject of the review by such professional review committee, if such member made a reasonable effort to obtain the facts of the matter as to which he acted, acted in the reasonable belief that the action taken by him was warranted by the facts, and otherwise acted in good faith within the scope of such professional review committee process and if such witness or participant acted in good faith within the scope of such professional review committee process.

(2) The governing board, the individual members of such board, and the entity which has established a peer review committee pursuant to section 12-36.5-104 shall be immune from suit for any damages in a civil or criminal action, including antitrust actions, brought by a physician who is the subject of any action taken by such board or members if such board or its members, acting as individuals, act in good faith. Good faith shall include reliance upon the recommendations of the review committee, but good faith shall not be presumed if the board or a member has knowledge concerning the review in question which would cause such reliance to be unwarranted.

Good faith shall also require that the board otherwise acted in good faith, including the consideration of any facts not previously available to and considered by the peer review committee, and that the board acted in reasonable belief that the action taken was warranted by the facts.

12-36.5-106. Committee on anticompetitive conduct. (1) There shall be established a permanent, independent committee of the board of medical examiners to be known as the committee on anticompetitive conduct referred to in this section as "the committee".

(2) The committee shall be composed of five persons, none of whom shall be a member of the board of medical examiners. Four members of the committee shall be licensed to practice medicine and actively engaged in the practice of medicine in this state and shall be appointed by the board of medical examiners. No member shall practice in the same medical subspeciality as any other member nor conduct his primary practice in the same county as any other member. One member shall be appointed by the governor and shall be an attorney licensed to practice in this state who has particular expertise and experience in the area of antitrust law.

(3) Each member of the committee shall serve for a term of three years and may be reappointed for one additional term. The initial committee shall be appointed as follows: Two members, including the attorney member, for terms of three years; two members for terms of two

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years; and one member for a term of one year. All subsequent appointments shall be for terms of three years.

(4) Any member of the committee may be removed by his appointing authority for neglect of duty, incapacity, or misconduct. Any vacancy shall be filled by the appointing authority for the remainder of the vacated term.

(5) The committee shall annually elect a chairman from among its members. Any three members of the committee shall constitute a quorum. Any action of a majority of those present comprising such quorum shall be the action of the committee. Committee members shall be compensated as provided in section 24-34-102(13), C.R.S. The committee may, in its discretion, utilize the expertise of consultants, including, but not limited to, legal, medical, and business specialists. The costs of such consultants shall be assessed and collected as provided in subsection (11) of this section.

(6) The committee shall adopt procedural rules, including emergency rules, pursuant to the rule-making provisions of the "State Administrative Procedure Act", article 4 of title 24, C.R.S., including rules related to the disqualification of a committee member, which rules shall be guided by section 24-4-105(1), C.R.S.

(7) Any physician who is the subject of a final action by a governing board, which action results in the denial, termination, or restriction of privileges at or membership in or participation in an organization, and who believes that such action resulted from unreasonable anticompetitive conduct shall have, as his sole and exclusive remedy, direct review of the record by the committee.

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Such review shall be limited to the sole issue of whether such final board action resulted from unreasonable anti-competitive conduct. Failure to exhaust this administrative remedy before the committee shall preclude the right of de novo review on the merits of the issue of unreasonable anticompetitive conduct.

(8) Nothing in this article shall preclude a physician or health care provider otherwise aggrieved by the final action of a governing board from seeking other remedies available to them by law, except as provided in subsection (7) of this section.

(9) Review by the committee shall be in accordance with the following procedures and, to the extent practicable, in accordance with the procedures used in the district courts of this state:

(a) Review shall be initiated by filing a verified complaint with the committee, no later than thirty days after receipt of a notice of final action by the governing board, alleging, with specificity, all facts disclosed in the record and all additional facts known to the complainant which would support his allegation that the final action taken by the governing board resulted from unreasonable anticompetitive conduct.

(b) The committee shall mail a copy of such complaint to the governing board and the professional review committee by certified mail, return receipt requested, within five days of the receipt of such complaint by the committee, advising them of their right to file a verified answer to the allegations stated therein. Receipt of such complaint by mail shall make the recipients thereof a party to these proceedings.

(c) The governing board and professional review committee shall have thirty days after receipt of the complaint to file their verified answer.

(d) Within thirty days of receipt of the complaint, unless the committee, for good cause shown, extends the time period not to exceed an additional thirty days, the committee shall determine whether the complaint alleges sufficient facts which, if true, would substantiate a finding of probable cause that the final action taken by the governing board resulted from unreasonable anticompetitive conduct.

(e) If the committee finds no such probable cause exists, it shall dismiss the complaint, which dismissal shall constitute final administrative action.

(f) If the committee finds such probable cause exists, it shall schedule a hearing. At such hearing the committee shall review the record below on the sole issue of whether the final action of the governing board resulted from unreasonable anticompetitive conduct and shall take evidence only with regard to the additional facts specifically alleged in the complaint or answer regarding unreasonable anticompetitive conduct, except when, in the discretion of the committee, the interests of a fair hearing demand otherwise.

(g) The attendance of witnesses and the production of books, patient records, papers, and other pertinent documents at the hearing may be summoned by subpoenas issued by the chairman of the committee or his designee, which shall be served in the manner provided by the Colorado rules of civil procedure for service of

subpoenas. Any subpoena issued pursuant to this paragraph (g) shall be enforceable in the district court.

(h) No evidentiary hearing shall last more than eight hours, unless the committee, in its discretion, determines that additional time is necessary in the interests of a fair hearing. Except as provided otherwise in this section, any evidentiary hearing shall be conducted in accordance with section 24-4-105(4) and (7), C.R.S.

(i) An evidentiary hearing shall be scheduled within a reasonable time after a finding that probable cause exists.

(j) Within a reasonable time after the completion of its hearing, the committee shall issue its written findings and final order.

(k) If the committee finds by a preponderance of evidence that the final action of the governing board resulted from unreasonable anticompetitive conduct, it shall issue its final order disapproving and setting aside such action or modifying the action taken by the governing board in whole or in part, which final order shall be binding on the parties. A copy of such order shall be mailed by certified mail, return receipt requested, to the parties.

(l) If the committee fails to find that the final action of the governing board resulted from unreasonable anticompetitive conduct as provided in paragraph (k) of this subsection (9), it shall issue its order dismissing the complaint, and the final action of the governing board shall stand.

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(m) If the committee finds that the record of the governing board is insufficient to permit the committee to reach appropriate findings with regard to unreasonable anticompetitive conduct, it may remand the case for further review by the governing board.

(n) In any case presented to the committee where the medical practice of the complainant constitutes a clear and present danger to patients, the committee shall refer the case to the board of medical examiners for such action as the board deems appropriate.

(10)(a) Following final administrative action by the committee, such action of the committee may be reviewed only by the court of appeals through appropriate proceedings brought pursuant to section 24-4-106(11), C.R.S.

(b) Following final administrative action by the committee, any party aggrieved by the final action of a governing board who wishes to challenge the action of such governing board, rather than the committee's review of such action, shall have the right to seek de novo review on the merits in a district court in Colorado. In no event shall the board of medical examiners or the committee be made parties to such a district court action.

(c) As a condition of filing a complaint under paragraph (a) of subsection (9) of this section, the complainant shall post a cash bond or equivalent liquid security of three thousand dollars to cover anticipated costs which may be assessed against him. Within thirty days of receipt of service of a complaint on a governing board, or concurrently with the filing of an answer, whichever is earlier, the governing board shall post a cash bond or equivalent liquid security of three thousand dollars to

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cover anticipated costs which may be assessed against it as a party. The committee may enforce this latter requirement through the district court.

(11) The committee shall assess and collect all costs associated with its activities, including attorney fees incurred by the committee, the per diem and reasonable expenses of each committee member, and other reasonable expenses, from the losing party or as the committee deems appropriate.

(12) The committee shall promulgate such rules and regulations as may be necessary for the implementation of this section, including mechanisms to secure the payment of costs as provided in paragraph (c) of subsection (10) and subsection (11) of this section.

(13) any member of the committee shall be immune from suit in any civil action based upon any proceedings or other official actions performed in good faith. Any witness, consultant, or staff member participating in good faith in the making of a report or any person participating in good faith in any investigative or administrative proceeding pursuant to this section shall also be immune from suit in any civil action.

PART 2

CONFORMANCE WITH FEDERAL LAW AND REGULATION

12-36.5-201. Legislative declaration. The general assembly hereby finds, determines, and declares that the

enactment of this part 2 is necessary in order for the state to comply with the provisions of the federal "Health Care Quality Improvement Act of 1986", as amended. It is the intent of the general assembly that the provisions of this part 2 are to be interpreted as being complementary to the provisions of part 1 of this article. The provisions of this part 2 are intended to be responsive to specific requirements of the federal "Health Care Quality Improvement Act of 1986", as amended. If the provisions of this part 2 conflict with the provisions of part 1 of this article, other than with respect to the specific requirements of the federal "Health Care Quality Improvement Act of 1986", as amended, the provisions of part 1 of this article shall prevail.

12-36.5-202. Rules and regulations – compliance with reporting requirements of federal act. Upon implementation of the federal "Health Care Quality Improvement Act of 1986", as amended, 42 U.S.C. secs. 11101 through 11152, and upon implementation of the federal data bank, the board of medical examiners shall promulgate rules and regulations to comply with such act, which rules and regulations are consistent with the standards and the reporting requirements of such act.

12-36.5-203. Limitations on liability relating to professional review actions. (1) The following persons shall not be liable for damages in any civil action with

respect to their participation in, assistance to, or reporting of information to a professional review body in connection with a professional review action in this state, and such persons shall not be liable for damages in any civil action with respect to their participation in, assistance to, or reporting of information to a professional review body which meets the standards of and is in conformity with the provisions of the federal "Health Care Quality Improvement Act of 1986", as amended, 42 U.S.C. secs. 11101 through 11152, upon implementation of such act by the federal government:

(a) The professional review body;

(b) any person acting as a member of or staff to the professional review body;

(c) any person under a contract or other formal agreement with the professional review body;

(d) any person who participates with or assists the professional review body with respect to the professional review action.

(2) Notwithstanding any other provision of law, no person, whether as a witness or otherwise, who provides information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, liable in damages in any civil action unless such information is false and the person providing it knew that such information was false.

(3) For the purposes of this section, unless the context otherwise requires:

(a) "Professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity and which is based on the competence or professional conduct of an individual physician, which conduct affects or may affect adversely the clinical privileges of or membership in a professional society of the physician. "Professional review action" includes a formal decision by the professional review body not to take an action or make a recommendation as provided in this paragraph (a) and also includes professional review activities relating to a professional review action. an action shall not be considered to be based upon the competence or professional conduct of a physician if the action is primarily based on:

(I) The physician's association or lack of association with a professional society or association;

(II) The physician's fees or his advertising or engaging in other competitive acts intended to solicit ore retain business;

(III) The physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with a member or members of a particular class of health care practitioners or professionals;

(IV) The physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service basis or other basis;

(V) Any other matter that does not relate to the competence or professional conduct of a physician.

(b) "Professional review body" means a health care entity and the governing body or any committee of a health care entity which conducts professional review actions and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.

DISTRICT COURT, WELD COUNTY, COLORADO

Case No. 92 CV 447, Division I

AFFIDAVIT OF RICHARD H. STENNER, PRESIDENT, NORTH COLORADO MEDICAL CENTER

WILLIAM JOHN NICHOLAS,
Plaintiff,

vs.

NORTH COLORADO MEDICAL CENTER, a Colorado not for profit corporation, and the GOVERNING BOARD OF THE NORTH COLORADO MEDICAL CENTER,
Defendants.

STATE OF COLORADO)
) ss
COUNTY OF WELD)

COMES NOW, Richard H. Stenner, after being first duly sworn and upon his oath, states as follows:

1. That I am Richard H. Stenner, President of North Colorado Medical Center, Inc.

2. That North Colorado Medical Center, Inc., is a private not for profit corporation created and operating under the laws of the State of Colorado.

3. That North Colorado Medical Center, Inc., is a tax exempt organization pursuant to the provisions of § 501(c)(3) of the Internal Revenue Code of 1986, as amended; its real and personal property are exempt from taxation pursuant to C.R.S. §§ 39-3-108, 39-3-109, as

amended; and its income is exempt from state taxation pursuant to C.R.S. § 39-22-112, as amended.

4. That North Colorado Medical Center, Inc. has no membership and is managed by a self-perpetuating Board of Directors of not less than eleven nor more than thirteen persons, four of whom are selected by the Board of Directors from the Board of Trustees of North Colorado Medical Center.

5. That the hospital facility is owned by Weld County, Colorado, which manages the property through the Board of Trustees of North Colorado Medical Center, which consists of seven members appointed by the Weld County Commissioners. North Colorado Medical Center, Inc. leases the hospital facility from the Board of Trustees pursuant to C.R.S. § 25-3-313.

6. That neither the State of Colorado nor any political subdivision thereof manages or controls the internal operations of North Colorado Medical Center, Inc.

7. That North Colorado Medical Center, Inc., owns all of the equipment and supplies and employs all of the personnel necessary and convenient to the operation of the hospital.

8. That North Colorado Medical Center, Inc., does not receive any tax funds or support from the State of Colorado or any of its political subdivisions.

NORTH COLORADO MEDICAL CENTER, INC.

By Richard H. Stenner
Richard H. Stenner, President

Subscribed and sworn to before me this 22nd day of January, 1993, by Richard H. Stenner, President of North Colorado Medical Center, Inc.

WITNESS my hand and official seal.

My commission expires: My commission expires Mar. 11, 199[Illegible]

/s/ [Illegible]
Notary Public